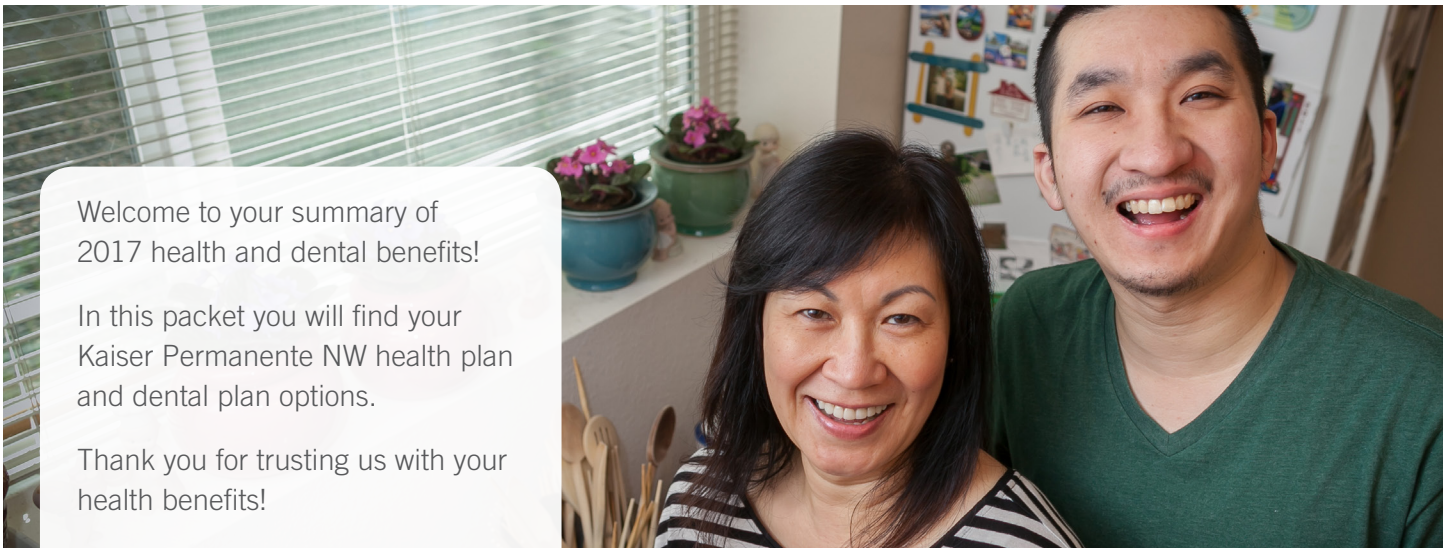
MRC Code: 2017 KaiserNW Plan

SEIU 775 BENEFITS GROUP

Your 2017-18 Health Plan Highlights



Welcome to your summary of 2017 health and dental benefits!

In this packet you will find your Kaiser Permanente NW health plan and dental plan options.

Thank you for trusting us with your health benefits!

Another year of health with the same great benefits

This year you can expect to receive the same high-quality medical, prescription and dental benefits. Here's a reminder of some of the services available to you!

- FREE Mental Health and Chemical Dependency Visits (In-Network/Outpatient)
- $15 Doctor Visit Copays
- $200 worth of vision supplies every two years
- Acupuncture
- Allergy shots
- Chiropractor visits
- Gastric Bypass
- Hearing exams
- Hospitalization
- Laboratory services
- Mammograms
- Maternity services
- Rehabilitative therapies
- Routine immunizations
- X-rays and diagnostic imaging

Save $185 by Using Urgent Care instead of the Emergency Room

When you need immediate care, look online at www.kp.org and search for urgent care to find your closest facility or make a same-day appointment with your Primary Care Provider.

Emergency Room	Urgent Care / Doctor Visit
$200 Copay	$15 Copay

Agency Providers Only: Open Enrollment Period - July 2017

For Agency Providers, July is your month to make these optional plan changes:

1. Add or remove dependents from your plan (Call us at 1-866-371-3200 for an enrollment form.)
2. Change your dental health plan (plan summaries and Dental Change Form attached)

Important Dates:

- **July 20, 2017:** Mail or fax your plan changes by this date for coverage starting in August.
- **July 31, 2017:** Last day to make plan changes for the 2017-2018 plan year.

More Plan Details

For questions, call the Member Resource Center - 1-866-371-3200 - Mon-Fri, 8am-6pm

www.myseiubenefits.org

Your Choice of Dental Plans:

	Willamette Dental Group	DELTA DENTAL
Annual Maximum	No Annual Maximum	$2,000
Deductible	$0	$0
Copay for routine exams	$15 Copay	Covered in full

Your dental plan is included in your $25 monthly co-premium and there are no plan changes from 2016.
Want to switch your dental plan? Complete and mail the attached Dental Change Form.
If you are an Agency Provider, send the attached Dental Change form by:

- **July 20, 2017:** for coverage starting in August.
- **July 31, 2017:** Last day to mail form for dental coverage for the year.

How to Schedule Your Free Mental Health Visits

When you think about staying healthy, is your mental health part of the equation? Mental healthcare can include psychotherapy, medication, group therapy, and complimentary and alternative medicines.

The first step is talking to your Primary Care Provider. Let them know you would like to access your mental health benefits. With your input, they can help guide you to the care that is best for you.

Make an appointment with your doctor online at www.kp.org or call:

1-855-6320-8280

Prescription Cost Comparison Chart

Prescription drug coverage is a big part of your health benefits. Make the most of them by managing your prescriptions wisely. Your cost for prescriptions will be less if you use a Kaiser Permanente pharmacy.

Rx Copay (In-network) for 30 day supply	At the Pharmacy	Mail order
Formulary Contraceptives*	$0	$0
Value Based Drugs**	$5	$10 for 90 day supply
Generic Drugs	$5	$10 for 90 day supply
Formulary Brand Name Drugs	$25	$50 for 90 day supply
Non-Formulary Brand Name Drugs	$50	$100 for 90 day supply

**Catholic Community Services Employees:* Your employer does not pay for contraceptive and sterilization services. Instead, Kaiser Permanente will provide separate payments for contraceptive services that you use, at no other cost to you, as long you are enrolled in your group's health plan.*

***The value based drugs are generic brands that treat: Diabetes, High Blood Pressure, High Cholesterol, and Heart Failure.*

Health Plan Benefit Summary

Kaiser Permanente Northwest Plan Summary

KAISER PERMANENTE

Effective Date: 8/1/2017

NOTE: This is a benefit summary, only, and is not intended to replace the specifics of the plan's Certificate of Coverage, Contract, or Evidence of Insurance. If there is a contradiction, the Certificate of Coverage, Contract, or Evidence of Insurance will take precedence.

Agency Providers only: Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan. You will be responsible for paying the full cost of the premium for your dependents. Contact your employer for premium rates.

Out-of-Pocket Maximum (Note: All Copayment and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted.)	
For one Member	$1,250
For an entire Family	$2,500
Office visits	
Routine preventative physical exam	$0
Primary Care	$15
Specialty Care	$15
Urgent Care	$30
Tests (outpatient)	
Preventive Tests	$0
Laboratory	$0
X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$50 per department visit
Medications (outpatient)	
Prescription drugs (up to a 30 day supply)	$5 generic/$20 preferred brand/$50 non-preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	$10 generic/$40 preferred brand/$100 nonpreferred brand
Administered medications, including injections (all outpatient settings)	$0
Nurse treatment room visits to receive injections	$5
Maternity Care	
Scheduled prenatal care and first postpartum visit	$0
Laboratory	$0
X-ray, imaging, and special diagnostic procedures	$0
Inpatient Hospital Services	$100 per admission
Hospital Services	
Ambulance Services (per transport)	$75
Emergency department visit	$200 (Waived if admitted)
Inpatient Hospital Services	$100 per admission
Services	
Outpatient surgery visit	$50
Chemotherapy/radiation therapy visit	$15
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance

More Plan Details

Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$15
Skilled Nursing Facility Services	
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	$0
Chemical Dependency Services	
Outpatient Services (Group visit ½ copay)	$0
Inpatient hospital & residential Services	$100 per admission
Mental Health Services	
Outpatient Services (Group visit ½ copay)	$0
Inpatient hospital & residential Services	$100 per admission
Alternative Care	
Alternative care (self-referred)	$15 per chiropractor visit
Vision Services	
Routine eye exam (through first month of age 19)	$0
Vision hardware and optical Services (through first month of age 19)	No charge for eyeglass lenses or frames or contact lenses every 12 months.
Routine eye exam (age 19 and older)	$10
Vision hardware and optical Services (ages 19 years and older)*	Balance after $200 allowance, once every two calendar years

* Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.

Additional Features

Online Access anytime, anywhere at no additional charge: kp.org

- Access medical records
- Refill Prescriptions
- Email doctor
- Check lab results
- Schedule appointments
- Health Risk Assessments – personal online tool for members

Facilities and Services: kp.org/facilities

- 37 Medical offices
- 8 Urgent Care locations
- 17 Dental offices
- The Portland Clinic (7 locations)
- 24-hour advice nurses
- Health coach services

Member Discounts: kp.org/choosehealthy

- CHP Active and Healthy
- Fitness club discounts
- Vitamins & supplements
- Alternative and chiropractic care

*Catholic Community Services does not pay for contraceptive and sterilization services

Exclusions and Limitations

The Services listed below are either completely excluded from coverage or partially limited. This applies to all Services that would otherwise be covered and is in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in the Evidence of Coverage (EOC). For a complete list and description of Exclusions and Limitations please refer to EOC. Acupuncture unless your employer Group has purchased the "Alternative Care Services Rider". Chiropractic unless your employer Group has purchased the "Alternative Care Services Rider" or the "Chiropractic Services Rider" (for self-referred chiropractic care). Cosmetic Services; This exclusion does not apply to Services that are covered under "Reconstructive Surgery Services" in the "Benefits" section of the EOC. Custodial Services. Dental Services. Designated Blood Donations. Employer Responsibility; We do not reimburse the employer for any Services that the law requires an employer to provide. Experimental or Investigational Services. Eye Surgery; Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures. Family Services; Services provided by a member of your immediate family. Genetic Testing. Hearing Aids unless your Group has purchased the "Hearing Aid Rider." Hypnotherapy. Infertility Services unless your group has purchased the "Infertility Treatment Services Rider." Intermediate Services; Services in an intermediate care facility are excluded. Low-Vision Aids. Massage Therapy Services unless your employer Group has purchased the "Alternative Care Services Rider". Naturopathy Services unless your employer Group has purchased the "Alternative Care Services Rider". Non-Medically Necessary Services. Services Related to a Non-Covered Service. Services That are Not Health Care Services, Supplies, or Items. Supportive Care and Other Services. Surrogacy. Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Travel and Lodging. Travel Services. All travel-related Services including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis), unless your Group has purchased the "Travel Services Rider." Vision Hardware and Optical Services unless your Group has purchased an "Adult Vision Hardware and Optical Services Rider" and/or "Pediatric Vision Hardware and Optical Services Rider." Vision Therapy and Orthoptics or Eye Exercises. This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Membership Services. In the case of conflict between this summary and the EOC, the EOC will prevail.

Delta Dental Benefit Summary

Delta Dental PPO Plan

DELTA DENTAL®

Effective Date: 8/1/2017 **Benefit Period Maximum (Per Person)** $2,000

Please Note: This is a brief summary of available benefits for comparison purposes only and does not constitute a contract. Once enrolled in a plan, you will have access to your benefits booklet which provides more details of your Delta Dental PPO plan. Please feel free to call our customer service department or visit our website at DeltaDentalWA.com if you have any questions.

You will likely experience the greatest out-of-pocket savings when you see a Delta Dental PPO dentist.

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Participating Dentist
Benefit Period Deductible			
Does Not Apply to Class I In Network – no deductible Out of Network - $50 per benefit period	$0/$0	$50	$50
Class I – Diagnostic & Preventive			
Exams	100%	80%	80%
Cleaning			
Fluoride			
X-Rays			
Sealants			
Class II – Restorative			
Restorations	100%	60%	60%
Endodontics (Root Canal)			
Periodontics			
Oral Surgery			
Class III – Major			
Dentures	80%	40%	40%
Partial Dentures			
Implants			
Bridges			
Crowns			

More Plan Details

Finding a participating dentist

Under your plan, you can choose dentists from two networks: Delta Dental PPO or Delta Dental Premier. You can find a participating, in-network, dentist in your area by visiting DeltaDentalWA.com and using our Find a Dentist tool. We recommend you select the Delta Dental PPO network to filter your search results.

The advantages of seeing a Delta Dental PPO or Delta Dental Premier dentist

We encourage you to see a Delta Dental network dentist because they provide services at discounted rates and file all claims paperwork for you. We will pay our portion and you're only responsible for your stated deductibles, coinsurance and/or amounts in excess of the plan maximums. In most cases, you will experience the greatest out-of pocket savings if you choose a dentist from the Delta Dental PPO network.

Visiting your participating, in-network, dentist

Be sure to tell your dentist you're covered by Delta Dental of Washington and give them your member identification number, plan name and group number.

Visiting a non-participating, out-of-network, dentist

You are not limited to using a Delta Dental network dentist. You may use any licensed dentist. If you choose a non-participating dentist, you will be responsible to have the dentist complete your claim forms and to ensure that the claims are sent to us. Claim payments will be based on actual charges or our maximum allowable fees for non-participating dentists, whichever is less. You're then responsible for any balance remaining after we pay. Unlike our participating dentists, we have no control over non-participating dentists' charges or billing procedures.

Confirmation of Treatment and Cost (Formerly called Predeterminations)

If you are considering extensive treatments such as crowns, oral surgery, periodontics or prosthodontics, we recommend you ask your dentist to request a predetermination from us. We will process the request and provide you and your dentist with a Confirmation of Treatment and Cost (Confirmation). The Confirmation will show you what procedures will be covered, an estimate of what Delta Dental of Washington will pay and your expected financial responsibility. Confirmations are based on the treatment plan submitted by your dentist and the covered dental benefits available to you at the time the Confirmation is issued. Confirmations are estimates, not guarantees of payment.

Have a question?

Give us a call at 800.554.1907, Monday – Friday from 7 am to 5 pm, Pacific Time. We're happy to help.

Willamette Dental Benefit Summary

Willamette Dental Group

Willamette
Dental Group

Effective Date: 8/1/2017

Underwritten by Willamette Dental of Washington, Inc. This plan provides extensive coverage of services to prevent, diagnose, and treat diseases or conditions of the teeth and supporting tissues. Presented are just some of the most common procedures covered in your plan Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.

BENEFITS	COPAYS
Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General & Orthodontic Office Visit	You pay a $15 Copay per Visit
DIAGNOSTIC AND PREVENTIVE SERVICES	
Routine and Emergency Exams	Covered with the Office Visit Copay
X-rays	
Teeth Cleaning	
Fluoride Treatment	
Sealants (per Tooth)	
Head and Neck Cancer Screening	
Oral Hygiene Instruction	
Periodontal Charting	
Periodontal Evaluation	
RESTORATIVE DENTISTRY	
Fillings (Amalgam)	Covered with the Office Visit Copay
Porcelain-Metal Crown	You pay a $250 Copay
PROSTHODONTICS	
Complete Upper or Lower Denture	You pay a $400 Copay
Bridge (per Tooth)	You pay a $250 Copay
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy – Anterior	You pay a $85 Copay
Root Canal Therapy – Bicuspid	You pay a $105 Copay
Root Canal Therapy – Molar	You pay a $130 Copay
Osseous Surgery (per Quadrant)	You pay a $150 Copay
Root Planning (per Quadrant)	You pay a $75 Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	Surgical Extraction
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	Not Covered
Comprehensive Orthodontia Treatment	Not Covered

More Plan Details

MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a $40 Copay
Specialty Office Visit	You pay a $30 Copay per Visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of $250

*TMJ has a $1000 annual maximum/ $5000 lifetime maximum

**Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

Exclusions

Bridges, crowns, dentures, or prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.
The completion or delivery of treatments or services initiated prior to the effective date of coverage
Dental implants, including attachment devices, maintenance, and dental implant-related services.
Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.
Endodontic therapy completed more than 60 days after termination of coverage.
Exams or consultations needed solely in connection with a service that is not covered.
Experimental or investigational services and related exams or consultations.
Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.
Hospitalization care outside of a dental office for dental procedures, physician services, or facility fees.
Maxillofacial prosthetic services.
Nightguards.
Personalized restorations.
Plastic, reconstructive, or cosmetic surgery and other services or supplies, which are primarily intended to improve, alter, or enhance appearance.
Prescription and over-the-counter drugs and premedications.
Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.
Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
Replacement of sound restorations.
Services and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved by a Willamette Dental Group dentist.
Services and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.
Services by any person other than a licensed dentist, denturist, hygienist, or dental assistant.
Services for the treatment of injuries sustained while practicing for or competing in a professional athletic contest.
Services for the treatment of an injury or disease that is covered under workers' compensation or that are an employer's responsibility.
Services for the treatment of intentionally self-inflicted injuries.
Services for which coverage is available under any federal, state, or other governmental program, unless required by law.
Services not listed as covered in the contract.
Services where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

Limitations

If alternative services can be used to treat a condition, the service recommended by the Willamette Dental Group dentist is covered.
Services listed in the contract, which are provided to correct congenital or developmental malformations which impair functions of the teeth and supporting structures will be covered for dependent children if dental necessity has been established. Orthognathic surgery is covered as specified in the contract when the Willamette Dental Group dentist determines it is dentally necessary and authorizes the orthognathic surgery for treatment of an enrollee, under age 19, with congenital or developmental malformations.
Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group dentist.
When the initial root canal therapy was performed by a Willamette Dental Group dentist, the retreatment of the root canal therapy will be covered as part of the initial treatment for the first 24 months. When the initial root canal therapy was performed by a non-participating provider, the retreatment of such root canal therapy by a Willamette Dental Group dentist will be subject to the applicable copayments.
General anesthesia is covered with the copayments specified in the contract if it is performed in a dental office; provided in conjunction with a covered service; and dentally necessary because the enrollee is under the age of 7, developmentally disabled or physically handicapped.
The services provided by a dentist in a hospital setting are covered if medically necessary; pre-authorized in writing by a Willamette Dental Group dentist; the services provided are the same services that would be provided in a dental office; and applicable copayments are paid.
The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance is covered if the appliance is more than 5 years old and replacement is dentally necessary.

SEIU 775
BENEFITS GROUP

Dental Change Form

To change your current dental carrier, please fill out and return the form below. If you have any questions, please contact the Member Resource Center at 1-866-371-3200.

If you are an Agency Provider, mail this form by:

- **July 20, 2017:** for coverage starting in August.
- **July 31, 2017:** Last day to mail form for dental coverage for the year.

PERSONAL INFORMATION

First Name:		Last Name:	
Street Address:			
City:	State:	ZIP:	
Phone:	Date of Birth: / /	Social Security: - -	Gender: ☐ Female ☐ Male
Agency / Payee Number:			

I want to change my dental insurance carrier to: (check one) ☐ Delta Dental OR ☐ Willamette Dental

Your dental change will take place the first of the month following the date your change form is received by the Trust Office. You will not be able to change your dental carrier again until 12 months after your change has taken place.

Your Signature: Date:

Please mail, fax or email your form to Zenith American Solutions, your benefits administrator by July 20th for August coverage.
For Agency Providers, please mail by July 30th, for 2017-2018 coverage.
If you have any questions, please call the Member Resource Center at 1-866-371-3200.

Mail to:
Zenith American Solutions, Inc
201 Queen Anne Ave. N, Suite 100
Seattle, WA 98109-4896

Fax to:
(206) 298-3424

Email to:
SEIU-HBT@Zenith-American.com